



Fig Computed tomography showing infiltration (arrowed) in right lung mid zone.

who had *Pneumocystis carinii* pneumonia (PCP).

The patient, a homosexual man aged 29, had been found to have antibody to HIV one year before, and was subsequently treated with zidovudine. The manifestation of infections, opportunistic or otherwise, is often more subtle in patients already taking zidovudine. When he noticed a loss of appetite and weight loss of seven pounds, he was found to have a temperature of 38°C and an erythrocyte sedimentation rate of 122 mm in the first hour. During investigation for occult lymphoma he underwent CT of the head, thorax, abdomen, and pelvis. Although chest radiography was normal, CT showed a patch of infiltration in the right lung mid zone (fig), which suggested PCP. In this case it was not possible to estimate lung transfer factor and, although saline induced sputum on six occasions and bronchoalveolar lavage samples yielded no pathogens, bronchoscopically directed biopsy specimens showed PCP on Grocott and periodic acid-Schiff stains. His response to treatment with co-trimazole, followed by inhaled nebulised pentamidine, was dramatic—with return of appetite, weight gain, and reduction in temperature and erythrocyte sedimentation rate.

The CT findings directed early investigations to the chest and encouraged early bronchoscopy, even in the absence of pronounced respiratory symptoms and the presence of normal blood oxygen concentrations. Thus CT of the thorax is worth considering when chest radiography is normal but PCP is clinically possible.

Yours faithfully,  
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TO THE EDITOR, *Genitourinary Medicine*

**Risk factors in the development of cervical intraepithelial neoplasia in women with vulval warts**

Sir,  
Argument for the provision of colposcopic

assessment and follow up of women with vulval warts is strongly supported by the experience of this department, which for two years has offered the screening colposcopy facilities proposed by Walkinshaw *et al.*<sup>1</sup> The routine provision of colposcopic examination in genitourinary medicine (GUM) departments also permits an approach to cervical disease that may be based on risk factors or known exposure to human papillomavirus (HPV) infection, rather than relying on the presence of vulval warts or on the results of cervical cytology (which are misleading in up to one third of all cases). The importance of identifying other sexually transmissible diseases (STD) in women with genital HPV infection was described by Kinghorn.<sup>2</sup> In the GUM clinics three broad groups of cervical disease can be commonly identified by colposcopy: HPV disease of the cervix, HPV disease of the cervix and other concomitant STD, and HPV or cervical intraepithelial neoplasia (CIN), or both, with or without other concomitant STD. The early detection of these diseases is facilitated by tracing sexual contacts of known infected male index cases and by offering yearly screening to women at risk via a recall register. This approach often permits identification of an abnormal transformation zone

Table Abnormal transformation zones in 329 patients attending a department of genitourinary medicine who had no cytological evidence of cervical intraepithelial neoplasia (CIN) or dysplasia

Results	No (%) with given result
Endocervical polyps	2 (0.6)
Cervicitis	20 (6.1)
Viral change since last	
Papanicolaou smear:	223 (67.8)
Previously negative	71 (31.8)
Previously positive	62 (27.8)
No previous result available	90 (40.4)
CIN I-III	19 (5.8)
Normal	65 (19.8)

before cytologists can detect abnormality. If more aggressive disease is identified, earlier referral to a gynaecologist is facilitated.

The table shows the results of a retrospective study of 329 consecutive patients undergoing colposcopically directed biopsy who had no cytological evidence of CIN (dysplasia). (Indications for colposcopy included the presence of vulval warts, a sexual partner with genital warts, cytology results reporting viral change, or a history of herpes genitalis. Indications for biopsy were acetowhite change (not affecting the endocervical canal) with or without areas of punctation or mosaic. Patients with acetowhite areas in the

endocervical canal were referred for gynaecological assessment). The detection of CIN in only 5.8% (19/329) of these women, compared with the finding of histological evidence of CIN in 29% (17/59) of women undergoing colposcopy because they had vulval warts,<sup>3</sup> may be of relevance in preventing cervical precancer. The findings in our patients may represent earlier detection than is possible when colposcopic examination is restricted to women with one (or often two or more) abnormal smears.

The question of who should undergo colposcopy may be answered best using principles of epidemiology. Women so investigated should certainly include all those with vulval warts, but including those at risk of infection with HPV also produces a high yield of abnormality. Provision of colposcopy solely for those with viral or other cervical smear abnormalities certainly appears to underdetect abnormal transformation zones.

Walker *et al* referred to the absence of an appreciable reduction in deaths from cervical cancer.<sup>3</sup> In women aged under 30 the death rate from this disease has increased threefold from 0.22 per 100 000 in 1968 to 0.69 per 100 000 in 1985. (PHLS CDC, Sexually transmitted disease in Britain, 1985. CDR 87/45 dated 13.11.1987, unpublished.) This increase roughly paralleled the epidemiological curve of the increase in numbers of total new patients attending GUM clinics during the same period.

The collaboration of gynaecologists with genitourinary doctors trained in colposcopy offers input at opposite ends of a range of disease. Surely at a time when resource management will demand validation of cost efficiency, a large multicentre study for three to five years should be established to assess the wider application of colposcopy within departments of genitourinary medicine.

Yours faithfully,

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TO THE EDITOR, *Genitourinary Medicine*

#### Low dose oral ofloxacin to treat gonorrhoea in Hong Kong

Sir,

The increasing prevalence of penicillinase producing *Neisseria gonorrhoeae* has necessitated the search for new, simple, and safe alternatives to penicillin to treat patients with gonorrhoea. In 1986 Henderson *et al* reported from Hong Kong that 50% of all new male patients with gonorrhoea were infected by penicillin resistant strains.<sup>1</sup>

Ofloxacin is a fluorinated quinolone that blocks bacterial gyrase and is bactericidal. Single dose oral treatment with ofloxacin for uncomplicated gonorrhoea has been reported. Rajakumar *et al* reported a 100% cure in 43 patients treated in Kuala Lumpur using a 400 mg dose of ofloxacin.<sup>2</sup> Henderson reported a 95% cure in 104 men in Hong Kong with a single 300 mg oral dose.<sup>3</sup>

During 1987/8 the first 50 men attending the British Military Hospital, Hong Kong, with untreated urethral gonorrhoea were treated with a single 300 mg dose of ofloxacin orally. Gonorrhoea was diagnosed by finding intracellular Gram negative diplococci in the urethral smears or by culture on selective media. All men were asked to refrain from further sexual activity and were examined again on days 7 and 21. Treatment failure was defined as the persistence of gonococci in the urethral swabs either on microscopy or culture when patients had abstained from further sexual intercourse. All 50 men were followed up for 21 days. There were no treatment failures. Eight had postgonococcal urethritis, which was defined by a urethral discharge containing more than 10 polymorphonuclear leucocytes per  $\times 1000$  field, but no gonococci, after abstaining from further intercourse. No drug side effects were reported.

The next 50 consecutive men with untreated urethral gonorrhoea were treated with a single 200 mg oral dose of ofloxacin. All were followed up for 21 days; 49 of the men were cured. Postgonococcal urethritis was found in eight. Of the 50 gonococcal infections, 22 were caused by penicillinase producing *N gonorrhoeae*.

The incidence of penicillin resistant strains of *N gonorrhoeae* isolated in men with gonorrhoea in Hong Kong remains at 50%.

#### Correspondence

Treatment with a single 200 mg dose of ofloxacin is as successful as previously reported treatment regimens using higher doses and provides a simple, effective, and inexpensive treatment for men with gonorrhoea.

Yours faithfully,  
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TO THE EDITOR, *Genitourinary Medicine*

#### Severity of urethritis in Reiter's disease

Sir,

Reiter's disease has been defined by the American Rheumatism Association as being necessarily associated with non-gonococcal urethritis (NGU), which may be low grade and is sometimes detected only from an early morning urethral smear.<sup>1</sup> I carried out a study to assess whether there was any significant difference between the severity of the urethritis in Reiter's disease and that in uncomplicated NGU.

I assessed retrospectively the case notes of 101 patients with Reiter's disease attending the department of genitourinary medicine of the Middlesex Hospital in 1970 to 1979. I excluded patients whose diagnosis was in doubt using the ARA criteria, those about whom information was inadequate, and one woman who satisfied the criteria. The study

Table 1 Point scoring system to assess severity of urethritis

Symptoms or signs	Score
Dysuria	1
Urethral discharge noted by patient	1
Urethral discharge noted by doctor	1
Urethritis* diagnosed from early morning smear only	1
Urethritis* diagnosed without early morning smear	2

\*Defined by 10 or more pus cells per high powered field in a urethral smear.